have been attributed to a temporary imbalance between cholinergic and dopaminergic activity (Leigh *et al*, 1987). This is supported by ocular movements under dopaminergic control (Rascol *et al*, 1989) benefiting from either anticholinergic or dopamine receptor blocking drugs (FitzGerald & Jankovic, 1989).

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Reviewing reviewers

SIR: I have read Ellenberger's book *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry* from cover to cover. Twice. Does this qualify me for some sort of record?

I was quite disappointed with MacDiarmid's reconsideration of the book (*Journal*, January 1990, **156**, 135–139), and taken aback that he considered it acceptable to admit he had not even read it all. I had thought that a *sine qua non* of reviewing was that the reviewer read the piece under review, be it never so long or tedious. It *is* long, but in my opinion not a page too long.

Perhaps because MacDiarmid is not familiar with the whole of the book, the impression I received from his review was not the same as that which I got from the book itself. Ellenberger's chapter on Janet is actually considerably longer than his chapter on Freud, yet approximately half of MacDiarmid's review deals directly with the latter.

I had found that this was one of the strengths of Ellenberger's book that he, as it were, put Freud into perspective, so that one could see what came before, after and at the same time, despite Freud's subsequent and now challenged pre-eminence. I don't think that this is reflected in MacDiarmid's review.

It may seem impertinent, but I don't think it unreasonable to request that people who review books should take the time to read them fully.

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Failure to convulse with ECT

SIR: Failure to convulse with electroconvulsive therapy (ECT) has been the subject of much recent discussion in your *Journal* (*Journal*, January 1988, **152**, 134–136; *Journal*, April 1988, **152**, 571; *Journal*, May 1988, **152**, 712–713). Reference has been made to a number of measures adopted to address this problem including vigorous pre-oxygenation, caffeine priming, reduction in methohexitone dosage, the use of chlorpromazine, cessation of benzodiazepines, the conversion from unilateral to bilateral electrode placement and the introduction of 'high energy' ECT machines. From a quality assurance perspective, it is disconcerting but important to reflect on the range of clinical activities derived from such measures. For this purpose, the psychiatrist's activities can be dissected, temporally, as follows: (a) what is done at the patient's bedside if there is no convulsion on application of the electrical stimulus; (b) what changes, if any, are made prior to the next ECT treatment session.

To the best of my knowledge, neither routine has been surveyed. Discussion with a number of colleagues working in different institutions suggests that an alarming variety of practices and protocols abound. To expound on (a), for example, some psychiatrists will not deliver a further stimulus if a patient does not convulse with the initial one. Other psychiatrists decide to give one, two or three further stimuli before either effecting a seizure or abandoning ECT for the day. Some administer a repeat stimulus immediately after failure of a preceding one. Others ensure that a designated period of time (usually up to a minute) elapses between administrations. Some psychiatrists will not change the original electrical settings for repeat stimuli. Others increase the duration but not the amplitude of the current. Others increase the amplitude but not the duration. Still others increase both the amplitude and duration. Increments in such parameters depend partly on the nature of the ECT machine but are, in any case, often randomly chosen. Some psychiatrists retain the initial electrode position, perhaps exerting more pressure on the patient's skin. Some convert from unilateral to bilateral placement. Many psychiatrists are hesitant or inconsistent in their routine. A familiar scenario may emerge – an electrical stimulus is delivered, a clinical fit doesn't ensue, the anaesthetist and psychiatrist look expectantly at one another, the attendant nurses look politely at the floor.

The described diversity of practice is, I suspect, not restricted to the Antipodes. It is lamentable. The administration of an electrical current to the head is not

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without morbidity and detractors. There is a need for a more formal survey and more uniform protocol, validated by empirical data. Of course the argument that efficacious electroencephalograph (EEG) seizure activity can occur in the absence of a clinically detectable fit impacts upon this subject and warrants further study. Nevertheless, in the interim, specific attention should be given to whether the application of a repeat stimulus significantly increases the likelihood of a fit and, if the stimulus is repeated, what its optimal characteristics (e.g. amplitude and duration of current) and 'climate' (e.g. degree of oxygenation of patient, concurrent drug therapy) should be.

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Asian suicides

SIR: Soni Raleigh *et al* (*Journal*, January 1990, **156**, 45–50) report that, among migrants from the Indian subcontinent, suicide accounts for 1.8% of male and 2.7% of female deaths. Since 1976, admission of Asians to the West Midlands Poisons Unit following deliberate self-poisoning has increased two-fold for men and four-fold for women. Using local Labour Force Survey statistics supplied by the Department of Employment, we estimate that one in 65 Asian women aged between 16 and 19 years is admitted to hospital following an overdose each year.

Thirty-one Asian suicides occurred in the city of Birmingham between 1984 and 1988. Like Dr Soni Raleigh *et al*, we found most cases were aged under 35. Two of the 17 male suicides and six of the 14 female suicides were by burning. Although only four males and two females died as a result of self-poisoning, seven males and seven females had documented previous suicide attempts, most being drug overdoses.

Risk factors for suicide following suicide attempts by Whites should not be applied to Asians. Among Whites, such factors include being middle aged to elderly, male, socially isolated and clinically depressed, but in the Indian subcontinent most suicides are young people with family problems who do not suffer from psychiatric illness (Merrill, 1989). The epidemiological findings of Dr Soni Raleigh *et al* and our preliminary results from Birmingham suggest that the characteristics of suicide by Asians in Britain are similar to those in the Indian subcontinent. Factors implicated in both suicide and attempted suicide among Asians are therefore similar (Merrill & Owens, 1986).

We have recently completed a clinical study of attempted suicide by Asian women which suggests that they may be at high-risk of future suicide. Compared to Whites, Asian women scored significantly higher on Beck's Suicide Intent (SIS) and Hopelessness Scales (HS) with those whose marital status was 'separated' recording especially high scores. A measurement of traditionalism and intergenerational conflict of values, the Traditional Values Scale (TVS) (available on request) was also administered. A significant positive correlation was found for non-traditionalism, conflict, SIS and HS scores.

We also administered the General Health Questionnaire (GHQ), HS and TVS to all fifth-form students at two Birmingham schools. A response of 'definitely have' to the GHQ questions 'have you recently thought of the possibility that you might do away with yourself?' and 'found that the idea of taking your own life kept coming into your head?', or a response of 'much more than usual' to 'have you recently found yourself wishing you were dead and away from it all?' was made by 24 of 72 Asian females (33.3%) and 16 of 78 Asian males (20.5%), but only three of 52 white females (5.8%) and one of 51 white males (2.0%). GHQ and HS scores were significantly higher for Asian females than other groups and were highly correlated with scores of non-traditionalism and conflict on the TVS.

Suicidal ideation, attempted suicide and suicide are much more common among young Asian women than young white women. Holding non-traditional values and being in conflict with parents are associated with suicidal ideation and, in those who have made suicide attempts, with high suicidal intent. Dr Soni Raleigh *et al* reported an increased incidence of suicide in young married Asian women and we found those who are married but separated and make suicide attempts have high suicidal intent. Although most Asian marriages are 'arranged', we do not believe that arranged marriages *per se* are a major cause of suicide or suicide attempts. Cultural expectations of newly-married Asian women tend towards conformity to prescribed roles. Those with scant regard for traditional values may consider, attempt or succeed in killing themselves.

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